UnitedHealthcare
A UnitedHealth Group Company

800 King Farm Boulevard, Suite 600
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November 22, 2011

Secretary Joshua Sharfstein
Chair, Maryland Health Benefit Exchange Board of Trustees
Submitted via electronic mail

Dear Chairman Sharfstein:

UnitedHealth Group is pleased to provide our comments and feedback on policy decisions before the Maryland Health Benefit Exchange Board of Trustees.

UnitedHealth Group is dedicated to making our nation's health care system work better. UnitedHealth Group's 87,000 employees serve the health care needs of more than 75 million Americans, funding and arranging health care on behalf of individuals, employers and government, contracting with more than 5,300 hospitals and 730,000 physicians, nurses and other health professionals. Our core strengths are in care management, health information and technology. As America's most diversified health and well-being company, we not only serve many of the country's most respected employers, we are also the nation's largest Medicare health plan— serving one in five seniors nationwide— and the largest Medicaid health plan, supporting underserved communities in 24 states and the District of Columbia. Recognized as America's most innovative company in our industry by Fortune magazine, we bring innovative health care to help create a modern health care system that is more accessible, affordable and personalized for all Americans.

UnitedHealth Group believes Exchanges have the potential to be valuable mechanisms to increase access to affordable health insurance. To realize this, we believe that Exchanges should be set up in a manner that develops fair and efficient markets, creates a positive consumer experience, advances consumer choice and innovation, promotes consumer responsibility, and balances national standards with state flexibility. What follows is a summary of our key principles that we believe further these goals. All of these comments and recommendations are based on our experience providing health benefits and service solutions to employers, individuals, and families. In addition to these comments, we also join the comments provided by the Maryland League of Life and Health Insurers.

Protect Consumer Choice To Minimize Complexity and Reduce Administrative Costs

In order to enhance competition, promote ongoing innovation, and increase consumer choice, we believe that all qualified health plans should be permitted to participate in the Exchange. Participating health plans should be encouraged to differentiate their plan offerings to appeal to a wide variety of consumers with different needs and preferences, while remaining consistent with federal standards regarding specified actuarial values. For example, at a particular actuarial plan value (e.g., Silver), some consumers might wish to purchase a high deductible health plan that would be compatible with a health savings account, while others may prefer a plan that offers more first-dollar coverage of pharmacy benefits and lower deductibles.

A state-based Exchange will ensure that the Exchange is responsive to unique state characteristics, including the specific dynamics of the individual and small group markets and the structure of public programs. Since insurance is regulated on a state level, an Exchange will generally be more flexible if it operates under the laws of a single state instead of a multiple states. Conflicting state regulations and statutes may make any kind of regional regulatory harmonization difficult to implement and maintain. A regional structure could include administrative economies of scale, but potentially, the same scale economies could be found by using a single administrative entity regardless of whether the state-level Exchanges are affiliated.

State-based Exchanges will benefit from uniform federal standards in areas where variation at the State level would add unnecessary complexity, such as risk adjustment mechanisms, quality improvement measurements, and uniform data transaction standards. States should also rely to the extent possible on existing review standards established by national accreditation agencies for use in the health plan certification process.

Preserve Existing Markets

Exchanges should supplement, but not replace, the existing small group and individual markets. Therefore, Maryland should preserve the existing market for health insurance outside of the Exchange, and should not force all individual health insurance products to be sold through the Exchange. Preserving a market outside the Exchange is not only beneficial for consumers, but is also supported by the express language of the Patient Protection and Affordable Care Act (PPACA). Specifically, Section 1312 of the law outlines clear Congressional intent that consumers should be empowered to enroll or select a plan outside of an Exchange, and that Exchanges should be voluntary. We believe that eliminating the external individual market would reduce competition, stifle innovation and lessen the ability of consumers to purchase insurance plans designed to fit their specific needs.

PPACA already provides a number of mechanisms to mitigate adverse selection against an Exchange. This includes the equal application of health care reform requirements to insurers operating inside as well as outside the Exchange, including:

- Adjusted community rating rules (adjusted only by age, tobacco use, geography, and family status)
- Individual and small group plans must cover the same essential health benefits
- Limits on individual out-of-pocket cost-sharing limits
- Treating all individuals as part of one risk pool (same for small group enrollees)
- Charging the same premium rates for a plan offered inside and outside the Exchange
- The operation of the risk adjustment and reinsurance programs

Perhaps the most significant protection against adverse selection against the Exchange is the fact that federal subsidies are only available through the Exchange. Ultimately, the viability of the non-group market will be highly dependent on the development of open enrollment rules, inside and outside the Exchange, that encourage consumers to obtain and maintain continuous coverage.

Furthermore, market rules applied inside the Exchange should not automatically be applied to plans sold outside the Exchange. Specifically, requiring that all of the same rules apply to plans sold inside and outside the Exchange or requiring that the same plans be sold inside and outside the Exchange without exception would likely serve to reduce consumer choice and competition. For example, some licensed health plans may not meet the requirements to become qualified

health plans (QHPs). A rule that these plans must meet the QHP requirements to compete in the outside market could theoretically exclude them from competing in the state. However, rules related to Open Enrollment should be equally applied inside and outside the Exchange. Applying the same enrollment rules regardless of the marketplace will help encourage consumers to obtain and maintain coverage. Additionally, it will assist in lessening potential adverse risk selection. Finally, as stated in the previous section, we believe that Exchanges should promote innovation and increase consumer choice with flexibility in plan design requirements as long as plans meet federal standards regarding actuarial value.

With respect to dental coverage, we believe that the consumers in the Exchange should benefit from the same choices available in the outside market. Consumers should have the flexibility to select coverage for dental benefits either through "bundled" medical products or stand-alone dental products in the Exchange. These options are available in the current market today, and consumers benefit from this competition and choice.

We believe that bundled products provide a simplified choice, and dental benefits do not need to be priced separately to provide transparency. Price and benefit comparisons can continue as they do today in the marketplace for stand-alone products, by adding the cost of medical and dental benefits together to compare the total to bundled products. In fact, we believe that separate pricing for an embedded pediatric dental benefit (part of the PPACA Essential Health Benefits package) would be arbitrary, inconsistent across carriers, confusing to the consumer, and could perpetuate health care system silos.

It should be noted that there is a policy question as to whether certain consumer protections under the PPACA would apply to a stand-alone dental policy, as such plans are currently considered HIPAA-excepted benefits. If dental benefits are integrated with the medical product, the PPACA consumer protections would be applied, which could be considered an additional benefit to the consumer.

Navigators, Agents and Brokers

Health care coverage is a complex decision, and individuals and small employers have traditionally relied on advisors to help guide them through the process. We believe that the evolving health care system should retain the highest level of quality regarding health care purchasing assistance, and the agent/broker relationship with clients should continue.

We support requiring a Navigator to meet licensing, certification or other standards prescribed by the state or the Exchange. We believe certification standards should be similar to the current standards for agents and brokers today supplemented with specific training for Navigators on PPACA requirements, Medicaid and CHIP, in addition to individual and small group products. Additionally, any rules related to agents and brokers should promote flexible roles for them to participate in both the Exchange and traditional commercial marketplace ensuring consumers are served by knowledgeable, resourceful advisors. Such flexibility builds on their current relationships with individuals and employers, and ensures that agents and brokers are not subject to limitations in performing an Exchange eligibility assessment. In short, eligibility assessments should not be restricted to Navigators.

We recommend that over time, the Exchange become the "source of truth" for all insurance affordability programs. This will help to track and better assist individuals as they move

between programs as incomes and circumstances fluctuate; advance the intent of a one-stop-shop for families with family members in more than one program; and, eliminate the need and inevitable inconsistencies associated with multiple enrollment databases.

Risk Mitigation

PPACA requires states to adopt systems of risk corridor and reinsurance for the first three years of the Exchange operation. We believe that the framework for a risk adjustment methodology for Exchanges should be established at the national level to ensure uniform standards and promote efficiency and consistency. The American Academy of Actuaries should be consulted for its recommendations on federal standards for risk adjustment, reinsurance, and risk corridor mechanisms. We believe it is important that the reinsurance, risk adjustment, and risk corridor processes are defined well in advance of the date that Exchanges become operational. They should be effectively integrated, promote stability in pricing, and not penalize efficient health plans that price responsibly to support health plans that either are inefficient or price irresponsibly.

Funding

PPACA requires that Exchanges must be self-sustaining and we believe Exchanges should develop a funding mechanism based on a per member cost that is agnostic to the selected metallic plan designs and not based on premium amounts. This will ensure that all consumers are treated equally as they undertake their shopping and selection process. Additionally, as fees and taxes are determined we believe that only qualified individuals and or QHPs inside the Exchange should be subject to any such fees and or assessments, and it should be clarified that any tax or assessment is user-based.

In light of a recently published report for the State of Ohio that projects the costs of operating a state based Exchange can range from $19 million to $34 million per year, we urge that any fees and taxes or assessment should be defined no less than twelve months in advance and adjusted prospectively. Using a prospective adjustment will avoid a year end true-up. Additionally, all funds collected must include a transparent plan/process as to how the funds will be attributed toward specified Exchange activities.

SHOP Exchange: Employer vs. Employee Choice

The Department of Health and Human Services (HHS) Notice of Proposed Rulemaking (NPRM) on the Establishment of Exchanges and Qualified Health Plans proposes allowing states to determine whether the SHOP Exchange will follow an employer or an employee choice model in the selection of QHPs offered to employees. We believe that in order to minimize risk selection issues a qualified employer should be required to select a metallic level of coverage and allow qualified employees to choose any available QHP offered at that level of coverage. Alternatively, an employer can select an issuer and allow employees to purchase any product offered by that issuer inside of the Exchange. These approaches comport with the language and intent of PPACA and promote employer and employee engagement in the shopping and enrollment process along with addressing potential risk selection issues.

Additionally, the SHOP Exchange should set minimum participation rules consistent with existing market practices in Maryland. By requiring the SHOP Exchange to be responsible for communicating and educating employers and consumers on the requirements of minimum participation, the SHOP Exchange helps protect against potential adverse selection, as well as promoting a stable risk pool.

Finally, we believe the Exchanges should adopt 2-50 employees as the definition for small group to ensure an orderly transition as well as alleviate potential implementation issues associated with establishing an Exchange. The 51+ employer group market is already very competitive and enjoys significant market leverage. Groups over 50 employees typically have the option to self-insure their benefits, and it is reasonable to expect that the lowest cost groups would opt to self-insure and the highest cost groups would find the community rates within the Exchange to be most attractive, making products within the Exchange increasingly more expensive for those small groups electing coverage. Limiting the small group market to groups with fewer than 50 employees will also minimize market disruption and avoid overtaxing Exchanges' administrative systems as they get up and running.

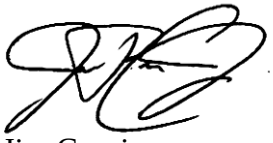
Facilitation of Premiums and Enrollment

We believe that for purposes of the individual Exchange, issuers should be responsible for collecting premiums directly from the individuals and subsidy administrators. As it relates to the SHOP Exchanges, we believe SHOPs must collect and distribute premium payments to issuers and issuers in the SHOP Exchange should not be permitted to accept payment directly for the employer groups. Finally, there should be firm standards for timely payment to issuers by requiring electronic funds transfers to issuers avoiding issues related to the 90 day termination provision.

Finally, we believe once the Exchange determines eligibility, QHPs should manage the enrollment process. Health plans currently understand the unique needs of consumers relative to enrollment, coverage issues, and premium payment and collection in the individual market. Exchanges should build on these existing capabilities by allowing QHPs to continue their relationships with consumers directly, thus ensuring QHPs engage consumers relative to their health care needs.

Thank you for the opportunity to provide UnitedHealth Group's perspective on these important Exchange policy considerations. If you have any questions, please do not hesitate to contact me or Ned Cheston on our Government Affairs team.

Respectfully submitted,



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Cc: Rebecca Pearce
Maryland Health Benefit Exchange Board members